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THYROIDECTOMY IN THE TREATMENT OF GOITRE.

BY JOHN B. ROBERTS, M. D.
PHILADELPHIA.

My object in bringing this topic before you is to call attention to the ease with which the enlarged thyroid gland can be enucleated and the mechanical symptoms caused by its pressure removed. After medicinal treatment has been employed sufficiently long to make it evident that no important change in size is to be expected, it seems to me that thyroidectomy need not be delayed.

Perhaps two months is as long as one need wait if during that time the approved remedies have been employed in full doses. It must be remembered that goitres not infrequently vary in bulk without relation to medicinal treatment; hence a diminution is not necessarily the result of the local or internal medication. If dyspnea, due to pressure on the trachea, is marked, or if hoarseness from compression of the current laryngeal nerves is present, one month's unsuccessful treatment by medicine would probably induce me to operate.

Parenchymatous injections of alcohol, tincture of iodine, or other irritants do not seem sufficiently successful or free from danger to be adopted as a routine, though cases may still come under my care in which I shall be willing to try them. Tapping or incision and packing of cystic goitre are available; but after the former the cyst is liable to refill, and the latter operation makes almost as much scar as, and is not much less serious than, thyroidectomy. Electrolysis does not seem to have given sufficiently certain re-

sults to make it attractive. Tracheotomy may be demanded when tracheal compression is marked, though in some cases subcutaneous or open division of the deep cervical fascia to allow the bronchocele to bulge forward will avert the threatened suffocation.

Division of the thyroid isthmus to lessen pressure, or ligation of the thyroid arteries to cause atrophy or prevent increased growth, are operations almost, if not quite, as serious as removal of a portion of the diseased gland.

I now speak only of thyroidectomy or removal of a portion of the thyroid glands; total extirpation is unwarranted, because the occurrence of myxedema as a result of the entire loss of the thyroid gland is pretty well established, experimentally and clinically. The most disfiguring and most compressing part of the goitre may be removed, and a portion of one lobe left to carry on the function of the gland. I would do this even if the part left was apparently not healthy to the naked eye. It seems pretty well established that a small portion of the gland, or a small accessory gland, if such be present, is sufficient to avert the occurrence of myxedema in patients subjected to removal of goitrous masses.

Thyroid feeding, the administration of thyroid extract, or the implantation of the thyroid gland of one of the lower animals, in the connective tissue or the peritoneal cavity of patients previously subjected to extirpation of the gland, may overcome the tendency to myxedema; but until this is really proved the surgeon should do only a thyroidectomy, and leave a portion of the gland in position.

I shall not go over the steps of the operation in detail, as they are sufficiently clear to any operator who is prepared to deal with sharp hemorrhage, and who is careful enough to avoid injuring the recurrent laryngeal nerves. A vertical incision is made in the median line of the neck or above the most prominent part of the tumor, and the necessary portion of the fibroid, cystic, or hypertrophic gland enucleated. Perfect asepsis or antisepsis is essential.

The enlarged thyroid in exophthalmic goitre has been subjected to operation, but the general character of this affection would deter me from operating upon the bronchocele, which is only one symptom of the disease; unless further statistics show its value in an unmistakable manner.

I add the reports of two cases to illustrate the subject. Neither goitre was of great size, but both were annoying to the patients. They were radically cured by operation. The enormous fibroid goitres seen especially in Europe would, of course, be more difficult to deal with, especially in regard to the control of bleeding.

THYROIDECTOMY FOR GOITRE OF EIGHT YEARS' DURATION; RECOVERY.

A single woman, aged 21 years, with a family history of phthisis, first noticed enlargement of the thyroid gland when she began to menstruate, at the age of 13. The enlargement rapidly increased for three years, when it began to press upon the trachea to such an extent that respiration was interfered with, and she was obliged to give up going to school because of the dyspnea that occurred while walking. After the lapse of a year the bronchocele began to diminish in size, but for the past three or four years had not changed much in bulk.

The patient had been under medical treatment for some time for the thyroid enlargement, without diminution in the growth; and I therefore determined in April, 1891, to excise

the most prominent portion of the gland. A four-inch incision was accordingly made in the median line of the neck over the most prominent portion of the enlargement. The middle lobe or isthmus of the gland was first enucleated, and I subsequently removed the entire right lobe. In the removal the sheath of the common carotid artery, with the descending branch of the ninth nerve upon it, was clearly exposed to view. A portion of the left lobe of the gland was then enucleated, making the size of the mass removed about that of a closed fist. The arteries requiring ligation were quite large and numerous. Sublimate gauze dressing was applied with considerable pressure in order to avoid oozing.

About half an hour after the operation the patient became so cyanotic from the pressure that the dressing, which had become saturated with blood, was removed. Her pulse became rapid and weak, but the removal of the dressing, the application of hot water, the administration of digitalis and other restoratives were followed by cessation of bleeding and quick reaction. A clean dressing was immediately applied. The next day the patient was in good condition with normal temperature. The wound healed promptly without suppuration or marked swelling. The patient was sent to the seashore about three weeks after operation with the wound healed, though her voice was quite husky. This was probably due to interference at the time of operation with the recurrent laryngeal nerve.

The woman has been seen repeatedly since operation, the last time being nearly three years from the date of the thyroidectomy. Her health has continued good; her voice has recovered its normal quality, and there is no evidence whatever of myxedema. It was because of the fear that myxedema might occur that I allowed a portion of the left lobe of the enlarged gland to remain. The goitre seemed to be of the ordinary hypertrophic variety, though no microscopic examination was made. The contour of the neck

is now almost perfect, except for the unimportant scar; and there has been no further growth in the portion of the gland allowed to remain.

THYROIDECTOMY FOR CYSTIC
GOITRE OF TWO YEAR'S DU-
RATION; RECOVERY.

A young man, aged 17, had noticed two years previously a small swelling in the front of his throat, about an inch and a half to the right and some distance below the Adam's apple. The tumor was not painful, but steadily increased in size until at the time he came under my observation there was some interference with respiration. He came to Philadelphia for the purpose of having the growth removed a year ago, but the surgeon who examined him advised against operative interference. When I first saw him, in November, 1892, the patient was the subject of a well-marked goitre. The girth of his neck over the most prominent part of the tumor was 15 3/4 inches. The enlargement involved both lobes of the thyroid gland, but the right was larger than the left. Stridulous respiration was marked, even when he was perfectly quiet and not taking any exercise. Breathing became easier as soon as the growth on the right side was pushed away from the trachea. This phenomenon I repeatedly tested, and it was very marked. Above the main mass on each side was a small nodule, somewhat separated from the rest of the tumor, but evidently being the upper portion of the lobe on the corresponding side. There was a well-marked groove between the two lobes, showing little involvement of the isthmus, and a furrow between the upper nodule and the main mass on each side. There was no exophthalmus, but there existed a doubtful systolic murmur. I treated the patient for some weeks with digitalis and quinine, with ointment of the red iodine of mercury and lanoline externally, and subsequently with fluid extract of ergot.

After a month's treatment I determined to remove the prominent

portion of the gland, which was making pressure upon the trachea. The patient took ether rather badly, as was to be expected from the interference with the respiration due to the growth. The right lobe of the tumor was exposed and was found to be cystic. The cyst was opened, and about an ounce and a half of dark-brown fluid was evacuated. The small nodule above and the right lobe containing the cyst were dissected from the underlying structures. The sheath of the carotid artery was exposed, and the lower portion of the mass extended close to the sheath of the subclavian artery.

Stridor was apparent after the operation; and some dyspnea remained, which was, however, relieved to a considerable extent by loosening the bandage. Four days later the dressing was removed. Union by first intention seemed to have taken place. A dressing of gauze and collodion was applied, and on the sixth day after operation the patient was allowed to get up. Four days later a slight hemorrhage occurred through the gauze and collodion dressing, as the result of a fit of coughing. Slight oozing took place for a couple of weeks through the opening made by the giving way of the union at this time. The blood-clot contained in the cavity left by the excision of the right lobe of the gland did not break down into pus, but gradually became organized. The patient's temperature was normal during nearly the whole of the convalescence, though at one time shortly after the operation it rose to 101 degrees. The patient was discharged about five weeks after the operation. His breathing had become normal, and the appearance of his neck was greatly improved, though there were still, of course, enlargements of the left lobe. There was no hoarseness remaining as the result of the operation, as in the former case.

A year later the patient wrote to me that he had had no trouble in breathing, that his voice was normal, and that there was no change in the appearance of his neck. The operation, therefore, was in every way satisfactory.

TUBERCULOSIS,

BY OSCAR S. PHELPS, M. D., OF
NEW YORK.

A former teacher, than whom there are few equals, if any superiors, Dr. A. B. Palmer, late professor of the Theory and Practice of Medicine in the University of Michigan, once said that the time would come when it would be a disgrace to have typhoid fever or a cold, both being filth diseases—the one from the decomposition of filth from without, and the other from the absorption of filth from within. The later discovery of the typhoid bacillus does not disprove his assertion, for the bacillus gets its virulent character from decomposing fecal matter just as the malarial germ gets its poisonous qualities from being first developed in the presence of decaying animal matter. So it is with tuberculosis. I am willing to go on record as prophesying that the time will come when it will be a disgrace to have consumption. That this position is not so extreme I hope to be able to point out later on. "The cloud no larger than a man's hand is already in the heavens." The late Dr. Hayes Agnew is reported to have said in his last address to a graduating class, that he believed within 50 years consumption would be as amenable to treatment as malaria is at the present time. The writer happened to know at that very time that Dr. Agnew was curing cases of phthisis by the application of the same principles which it is the object of this paper to set forth.

The history of tuberculosis is as old as the human race, and its destructive powers are illustrated by its percentage of the total mortality—14 per cent.—figures that are appalling. War and pestilence are but pigmy instruments in the hands of death!

To follow its etiology through the history of medicine would be to wade through a mass of literature so great and so contradictory that the student of medicine might well pause before such a task. The common, up-to-date view of the subject

is that the so-called Koch's bacillus is the cause of the malady, and that without its presence the disease cannot exist. So general and so classical has this theory become, that to deny it would be to bring down upon the devoted head of the objector the scorn and anathemas of almost the entire medical profession.

Last month it was our privilege to listen to three scholarly and able papers on tuberculosis, read before the Harlem Medical Association. The first one was by Dr. Bottome, and the writer said in substance that while the bacillus is the accepted and undoubted cause of tuberculosis, and is the true source of infection, it is equally true that all are not vulnerable to it—in fact, that the majority are not susceptible to the contagion. He further pointed out that the tubercular diathesis, hereditary or acquired, must exist before the bacillus can gain access to the victim, and set up the diseased action that constitutes tuberculosis. With all due respect to the writer and those who with him voice the above opinion, I would ask if that is not begging the question. Diathesis, forsooth! if there is one word more than another in our medical vocabulary that is misleading and meaningless, it is diathesis. I am constrained to exclaim, "How long, O Lord, how long!" shall this poor little word be made the scapegoat of our ignorance. I can but consider the up-to-date theory a tacit acknowledgment that we must first have a case of tuberculosis before we can have the bacillus, either in the blood or sputum. What place, then, would I give the bacillus? Practically the same relation to the tubercular patient as that of the larva *musca carnaria* to the carrion. In the one case you must have a dead animal; in the other, a dying one. I will concede with Gibbes and Shurly, that the ptomaines evolved by the decomposition of the excreta of the colonies of bacteria feeding upon the diseased tissues increases the activity of and modifies the disease simply by poisoning; and I believe that whatever effect the gold and manganese treatment proposed

by them, J. Blake White and others, it is due principally to its action in neutralizing these ptomaines. Consequently, I do not believe tuberculosis to be infectious or contagious. In this I am borne out by clinical observation and experience.

But you may well ask, If you thus dispose of the bacteriological theory, what have you to offer in its stead? I submit it is a very pertinent question. Before unfolding my position, however, I wish to offer some reasons for the position already taken. I have examined the blood of many individuals, and have found these persons to be in a tubercular state—I had almost said “diathesis”—from three to six months before there were any physical signs or bacilli. Then both of these were developed, and the cases that were not treated until this late stage, and then upon the old lines, finally succumbed to the inevitable, and went to swell the list of “died of consumption.” But what is still more specific, the bacilli of tuberculosis have been injected into the blood of a healthy individual without deleterious results. The writer, with others, examined the blood of the experimenter previous to the trial, and found it free from signs of tuberculosis. I refer to the well-known case of Dr. Robert L. Watkins. The bacilli were injected into his blood at the Loomis Laboratory more than a year ago, and up to date the doctor does not show the least sign of tuberculosis. In several of the daily papers the case of Dr. Byron has been published, in which the statement has been made that he became inoculated in the same laboratory with bacilli, accidentally, it is supposed—and that he is now suffering from tuberculosis. In reference to this statement, I have to say that it is highly improbable that he was so inoculated. But granting that he was, and also that he now has tuberculosis, I maintain that he was in a tubercular state long before the inoculation, and that the microscope would have shown, as it has in others, its existence several months before there were any bacilli to be found, or any physical signs that

could be recognized by the most careful examination.

At this point in the discussion you will have doubtless anticipated me in what I am about to say, viz. that tuberculosis is not infectious or contagious, and that the only good results that can come from the popular teachings on that point are increased efforts at cleanliness.

We are now led to offer for your consideration the true causes of the disease which forms the topic now before you. Some one has said of cancer, that it is a manifestation of tissue change under mob law, and it would seem to be not an inapt definition of tuberculosis. It is caused by a peculiar state of malnutrition, in which two important elements figure—starvation and poisoning—auto-infection, if you please. If a considerable portion of the food taken undergoes decomposition instead of assimilation, it follows, first, that the individual is deprived of sufficient nourishment, and, secondly, that he will be more or less poisoned by the products of that decomposition. This will occur slowly at first, but as the organs of elimination themselves come more and more under the influence of the poisonous gases, ptomaines and other products of decomposition, they, in a corresponding degree, fail to protect, and absorption begins. At this point the microscope reveals the first signals of warning in the blood. These are easily seen by the experienced eye, but are easily over-looked by the microscopist who is hunting for the bacilli of tuberculosis.

The advances may be rapid or slow, according to varying conditions which we will not stop to name. The exact initial lesion is believed to be a stasis at the point in the tissue, lung or other part, where a loaded white blood corpuscle cannot get through the capillary. The blood serum then exudes, carrying and depositing certain elements, prominent among which are the enlarged fibrin filaments, these impinging still further upon the adjacent capillaries and tissues, and we have the first condition of necrosis. It is impossible within the scope of this

paper to even hint at all the phenomena present in the formation of a tubercle, and reference will only be made to a few of the more salient.

As scavengers, the white blood corpuscles pick up the products of the decomposition that have been absorbed from the blood stream, and like the fox in the fable that stuck in the hole when he had filled his belly with fat chicken, they lodge in the capillaries, as described above. In the earlier stages only a few corpuscles are observed to be loaded, and only now and then one so much enlarged that it cannot pass the smallest capillaries. It would seem, then, that to cut off the supply of decomposing matter in the alimentary canal would at once to put a stop to the process of destruction by clearing the blood stream of the offending matter. While this is in a large measure true, there is one element that is no so easily disposed of. This has been called the third blood corpuscle, or tubercular granule, by Dr. Watkins. It is almost superfluous to point out that in the decomposition of animal and vegetable substances certain ferments come in as an important feature of the process, and that these have the power of indefinite reproduction under favorable circumstances. One of these is thought to have the power of reproduction in the blood, which may account for the difficulty of removing it. This complicates what would otherwise be a comparatively easy procedure, viz., to rid the blood of these products of decomposition as already suggested. If this property of the so-called third blood corpuscle, or tubercular granule were proven, how much it might aid us in the cure of our cases does not at present appear. It is certain that by cutting off the supply of decomposing matter in the alimentary canal we begin to restore nutrition all along the line. The eliminative organs begin to regain their normal status, and to again act as a barrier to the absorption of poisonous matter into the blood. It now remains only to see that we get vigorous tissue building

with the least expenditure of vital force, and we are in full command of the situation.

Before entering upon the details of this most important part of our discussion, allow me to say that there is no royal road to the cure of tuberculosis. The renowned Fothergill once while discussing the merits of expert physical examinations of the chest, and giving due credit to their value, projected this aphorism, "Look at your patient," and in that saying he, like many another, "build-ed better than he knew." Look at your patient through the microscope, look at his blood, sputum, fecal matter and urine. In that way alone can you find out his exact condition, and the special work you have before you in his individual case. It is the key to the entire situation—diagnosis, present status and guide in your work of restoring his nutrition.

In the choice of proper food you cannot be guided by the patient's taste, or his feeling of well-being in the giving or withholding of food. If you adopt a certain course of diet, and wait to see if he does well or ill, you may not only lose valuable time, but do him an injury. As a matter of fact, he will die before you have discovered by such experimentation just what food to give him. The effect of your feeding must be watched daily with the microscope, and the evidence thus obtained must be your guide in giving or withholding, increasing or diminishing—in short, in making such changes as are needed to accomplish your purpose. From this point of view you will observe there can be no hard and fast rule for feeding. The one thing before us is a case of diseased nutrition which must be restored; and to succeed we must go about it in a scientific manner. To follow general rules is to utterly fail. In the beginning of the treatment of a given case successful feeding with its accompanying details of management are a matter of hair-splitting precision, for we have to "pull against a head wind and flood tide." In the choice of material, I may say that the ni-

trogenous foods are in a general way found to be best adapted to our purpose, first, because they contain in the highest degree the tissue-building elements most needed; secondly, because they are less prone to fermentation, and thirdly, because too small a proportion of available nitrogenous food is as a rule consumed by civilized man. A considerable list may be mentioned, with some reasons for a choice: beef, mutton, fowl, eggs, milk, fish, gluten of wheat, peas, etc. It is not enough that an article contains the requisite constituents to build up the diseased organism. There may be plenty of gold in the hard quartz rock, but unless we have the suitable appliances to extract it, it might as well be lead.

Let us briefly consider the physical status of that portion of the human family we have most to deal with, the average American—that high pressure specimen of the genus homo, whose highly developed nerve centres consume such an undue share of the vital forces that the vegetative organs have but little left them to perform their functions. It is plain that an individual thus handicapped cannot successfully rebuild his tissues from crude materials. Himself a product of evolution, and a long remove from his earlier progenitors, he should be given food that is equally high in the scale of evolution, a food which requires the least expenditure of vital force for the process of digestion. Such a choice of food should be made that will answer as well all the requirements of his body. With this principle in mind, we shall have little trouble in selecting the proper diet with which to begin the feeding of a tubercular patient. Then, with the aid of the microscope, as pointed out above, the work can be conducted along safe and successful lines.

The next step to be considered after feeding, and ranking next in importance, is cleanliness. This must be done thoroughly and systematically, and as water is the best solvent, it must be used freely. When

the reaction came from the practice, now long ago, of withholding cold water from the thirsty fever patient, a renowned teacher said to a medical class: "Use water; use it freely; use it internally, externally and eternally." Cleanse your tubercular patient; his skin, alimentary canal from mouth to anus; his liver and his kidneys. The skin should be cleansed with warm water and soap, or water made alkaline with ammonia, following this by gentle rubbing, and if he has night sweats, rub with alcohol 128, quinine, 2; acid. sulph., 1, and glycerine 16 parts. In washing the alimentary canal begin with the teeth; brush them with warm water and soap; rinse the mouth with warm water and sodae phos., a teaspoonful to a glass of water. The stomach may be washed by filling it with warm water by means of a funnel and tube, and then siphoning it out; but an easier and more practical way is to direct the patient to sip slowly a pint of hot water, so hot that he must of necessity sip it slowly, with a half-teaspoonful of bicarbonate of soda, or in some cases, two teaspoonfuls of sodae phos., one and a half hours before the meals. When taken very hot, downward peristalsis is produced, and the duodenum is cleansed as well, the gall bladder emptied, and the small intestine in a measure flushed. The stomach is thus cleansed of mucus and germs of fermentation, and is in a good condition to receive food. Next the colon should be flushed with warm water every day, or every other day, as seems best to the physician. To do this effectually, four quarts of water should be used, the patient lying on his back or side, or in some cases the knee-breast position is better. Some objection has been made to this procedure, the objectors claiming over-distension of the bowels, loss of tone, etc. The best answer to these objections is that in any case of constipation the colon is distended with fecal matter and gas, both of which are more stimulating than water, to say nothing of their poisonous qualities, which

are often absorbed. When there is a regular evacuation every day, only the lower four or six inches of the bowel are emptied, the remainder being more or less distended all the time. Is it not better, therefore, to wash it clean, thoroughly flushing the sewer of the body? This gives the muscular fibres an opportunity to rest and contract, the very conditions needed to favor a return to a normal state. The water distension is only for a few minutes, while the fecal distension is more or less continuous. I may add here that, in cases of extreme tendency to fermentation, various antiferments have been proposed, and used. Creosote, carbolic acid, phosphate of soda, etc., have all been recommended for this purpose. If used at all, they should be taken one and a half hours before a meal, otherwise they will interfere with digestion. Practically I prefer to meet the condition by changes in the diet, and have rarely failed to accomplish my purpose. In the manner of feeding a tubercular patient, I have refrained from going too much into details, for the reason that I wish to emphasize the principles upon which the condition of malnutrition must be met, rather than to offer a routine procedure, which would, as in many other notable cases, result in failure, and the value of a correct principle be lost through being condemned.

Let me remind you that any particular article of food, together with hot water, cannot, like the inferior maxilla of that long-eared quadruped of old, be seized, and sallied forth with to slay its thousands. The desire for such a weapon with which to combat tuberculosis is very strong, as was proven a few years ago when there was such a rush to Europe to obtain from first hands some of the then precious tuberculin which, with no other skill than that necessary to manipulate a hypodermic syringe, was to place this dread disease completely under our control. In mechanics there has been a great deal of wasted energy in trying to invent and perfect a complicated machine to per-

form some certain work, and at last some simple device has been hit upon that has solved the problem perfectly, and the only mystery has been why it had not been thought of before. So in this connection, may it not be pertinent to suggest that we turn our attention from the consideration of the infinitesimal, as pursued by the bacteriologist, to the more homely subject of the evolution and devolution of our bodies?

My position may be summarized as follows: Tuberculosis is not caused by the tubercle bacillus; it is neither infective nor contagious; it is not hereditary; its causes come from within the body, not from without; it is both a preventable and a curable disease.

143 West 131st st., New York.

Society Reports.

CINCINNATI OBSTETRICAL SOCIETY, OCTOBER 25, 1894.

CASE REPORT—DR. ZINKE.

Mr. President:—This specimen I removed last Thursday from a young unmarried woman, aet. 30, who presented the following history. She always enjoyed good health, and never had any menstrual difficulties. The evidences all pointed to her having led a virtuous life up to the present. Her family history is excellent; her father, mother and brothers are all living and well. This growth appeared a year ago, and seemed to follow an injury of the breast some three or four months previous to that. It remained stationary and did not give her any inconvenience until the last three months, when it assumed a very rapid growth, but still did not pain her in any way. Upon physical examination it was found to be freely movable and hard,

but not painful. It was so large that she had to pad the other side to make herself appear even. Because of the rapid growth I advised its removal. I have not yet satisfied myself of the nature of the growth. I believed it would be easy to get out, and I left considerable skin to bring the wound together. After removing it, there was a saucer-shaped cavity left, part of which was hard. I removed this, and it appears malignant. There has not been the least trouble with the wound, which is healing very nicely. Only for the infiltration surrounding it, I should consider the growth harmless in nature.

The next specimen was removed from a young woman, aet. 18, single, who had no special trouble during menstruation, or in the intermenstrual period, but always complained of a sense of heaviness in the region of the pelvis, and occasionally some sharp, lancinating pains, especially preceding menstruation. She was examined at Ironton, Ohio, by several physicians, who said she had a tumor. Having been examined before, I did not hesitate to make an examination myself, and I found the whole pelvic cavity filled out by a tumor, starting apparently from the right broad ligament; the uterus was pushed over to the left, and the tumor at the time resembled an edematous fibroid. Upon opening the abdominal cavity, the cyst sprang at once into view, and it had all the appearance of a parovarian cyst. I punctured it with the trocar and let out the fluid, which was absolutely transparent, and looked almost like filtered water. I removed the whole of the broad ligament, with the ovary attached to it. The ovary was very much enlarged, and had undergone cystic degeneration. After I had removed part of it through the abdominal incision, I found it was interligamentary, but had grown from the broad ligament so as to form a very nice pedicle. I present the specimen because it so beautifully illustrates the interligamentary cyst. If the ovary had been healthy, I would have been tempted to have simply shelled

the cyst out, which could have been very easily done.

The next specimen is a fibroid polypus, springing from the os internum, removed from a woman about 45 years of age, who had had menorrhagia for the last 12 years, and a metrorrhagia within the last two years. Occasionally this tumor, which was at that time somewhat smaller, would be completely extruded from the vulva, and she, thinking it was her womb, would push it back. She consulted several physicians, who advised its removal, but this she would not permit. When I was called to see her, she was almost moribund from loss of blood and from sepsis. I had her removed to the hospital, and the next day I removed the tumor. The hemorrhage was very profuse, but was controlled by applying hemostatic forceps, and removing them after 24 hours. Since removing the growth the symptoms of sepsis have subsided, and I think the patient will leave the hospital in a week or two. This woman, I have no doubt, had she refused an operation, would have succumbed. The anterior part of the tumor has a part, about the size of a dollar, which is sloughing because of gangrene, which is, however, probably not very deep. Other parts are also gangrenous.

Dr. R. B. Hall:—

Mr. President:—I would like to make a few remarks in reference to the second case reported. First, I want to congratulate the doctor upon the good prospects of recovery of the patients. One remark the doctor made, in reference to the enucleation of the broad ligament cyst, I think is likely to be misleading, although I will grant it applies to this case. The operator was fortunate enough to be able to ligate below the cyst and remove it as a whole, but he remarked how easily it could be peeled out, and again how easily the hemorrhage is controlled in these cases of interligamentary cyst. I will grant, in a case such as this, the hemorrhage probably would not be very troublesome, but I have had experience in enucleating some of these cysts, in which there was hemor-

rhage. For instance, take a tumor in which a large portion goes down into the broad ligament, and where, when you have enucleated clear down to the bottom of the pelvis, it separates the broad ligament close to the uterus; in these cases we do have hemorrhage, and hemorrhage that is not controlled by pressure. I have seen several cases in which a number of ligatures had to be applied. It is the kind of cases which, it has been said, makes men's hair grow white. Take tumors weighing ten to twenty pounds, which have separated the broad ligament, and you must peel out a portion of the tumor the size of an adult head; the patient loses large quantities of blood by the best method of operating possible—that is, enucleating to the crest of the ilium and then towards the uterus, the recognized and most skillful method—and before you can get the thick portion of the tumor away, so you can get at the bleeding points, the patient has lost a large quantity of blood. In other words, these are not easy cases, as intimated by the doctor, unless you have a small tumor like this. I remember reporting a case four or five years ago of an interligamentary cyst, not much larger than this, which could not be ligated below the cyst, and had to be enucleated, and that patient lost much blood during the operation. In these cases, notwithstanding you may put on catch-forceps and use every precaution, it is difficult to find the bleeding points. While an easy case is perfectly easy, the difficult cases, where a large tumor dissects down in the broad ligament, are anything but easy, and they must always be classed as bloody operations, in which the patient may die on the table from hemorrhage. Dr. Goodell has described these operations more graphically and truer to nature than any other writer with whom I am familiar. He says these are the cases in which there is great danger of death occurring on the table from hemorrhage, and my experience leads me to believe they are. I have had the misfortune to have seven or eight cases of large interligamentary

tumors, in which I had to dissect them out of the broad ligament, but have never had the misfortune to lose a patient on the table from any cause.

Dr. Palmer:—Mr. President:—A point occurs to my mind, in reference to the first case Dr. Zinke has reported. I have no doubt this was at first an innocent tumor of the breast, and possibly it is an innocent tumor still. I have no doubt it was until quite recently. The point in reference to those mammary amputations is this: Should we always take out every tumor we find in the mammary gland in women beyond 35, 40 or 45, or at or about the menopause, whether it is an innocent or malignant growth? Certainly cut it out if malignant, but should we exsect the breast every time we find a tumor in it? It seems to be the opinion of some that we should operate, whether the axillary glands are involved or not, because all innocent tumors here situated are likely to undergo malignant degeneration at any time. Personally, I have been disposed to wait and not take out everything, if the general health is good and the tumor has been present for some time. If it is malignant, take it out as soon as possible; but if it is innocent, wait at least some weeks or months. I am not disposed to remove every tumor at once, irrespective of kind or degree.

Dr. Johnstone:—Mr. President:—There have been so many points brought up, and I agree so fully with most of them, it is scarcely worth while to discuss it. In reference to these operations on the breast, I believe my experience leads me to be more radical than ever, but I do it in this way: I start my operations as exploratory incisions of the breast, and by so doing I have frequently saved a complete extirpation by removal of parts of the breast, when I found dilated milk ducts, etc., which were thoroughly cleared out, and I know women with part of the breast removed who are now enjoying perfect health. I make a short incision (an inch and a half is plenty long enough), when the growth has lasted

several weeks or months, so it will be part of an ellipse, and then am guided by what I find. I believe it is best to make an exploratory incision, so we can prolong it into an ellipse and make any operation we may desire. I believe this is best unless there is not the shadow of a doubt. But I believe the sooner a cancer is out the better are the chances of the patient. It begins as a local disease and becomes constitutional only by waiting, and with this kind of a dread over every lump that comes in the breast we should not too long delay exploring it. I believe these very dilated milk ducts are sometimes the starting point of cancer, just like, for instance, a simple lipoma may take on a carcinomatous degeneration. As for enucleation of tumors, Mr. President, I have had my share of experience. I have never lost a case, I am happy to say, although I have had to leave some very raw surfaces. In reference to the hemorrhage, we can now do a great deal we could not formerly. When you cannot get at the capillaries and stop the hemorrhage, and in this I think the Trendelenberg position would help considerably, we should find the vessel if we possibly can, but if we cannot, and the shock is increasing, and the hemorrhage is just from a general oozing, we should pack with gauze and remove it at the end of 48 hours, and I have not the slightest doubt in that way a good many cases Goodell referred to may be better treated. We can now do such operations with more certainty. Mr. President, I believe that is all, except to congratulate the doctor upon the happy result in the case of fibroid, because it is wonderful how stupid some people are, and how frequently we find just what was found in that case.

Dr. Zinke—Mr. President: Of course my remarks pertained only to the specimen presented. I appreciate very much the remarks made by Dr Hall, in reference to the extensive hemorrhage we may have, where there is no pedicle and the tumor dips down deep in the pelvic cavity and the ligaments are stretched like

a tent over the tumor, as it were. In a good many of these cases it is best not to be so thorough in the removal of the tumor, but leave some of it behind, to be cast off afterwards, and stitch the sac to the abdominal wall. We can thus save more lives. There is no doubt, if we keep the pelvic cavity free from contamination, so no pus that may be formed afterwards can perforate the pelvic cavity, it is very rare any trouble will occur. I speak only of those cases in which you are bound to lose your patient if you continue, and there you give the patient a much better chance if you take your chances with granulations.

Dr. Johnstone—Mr. President: I would like to detail a case. A friend had had interligamentary cyst three years ago, and I tapped it, giving thorough drainage without trying to remove the growth. I replaced the tube once or twice, and the patient wore it eight or nine months, and is now as sound and well as can be. The sac was fully a third of an inch thick, and was stitched to the abdominal wall, and thorough drainage secured through the vagina.

Dr. Zinke—Mr. President: The point is: When shall we stop and pursue the other course? I believe in being thorough and getting rid of everything by all means if possible, but if it is evident that the hemorrhage is increasing and the patient becoming pallid and the cold perspiration appearing, we had better stop, pack with iodoform gauze, stitch it as well as we can and shut off the peritoneal cavity thoroughly. I pursued that plan in the case of extra-uterine pregnancy, where there was a circumscribed involvement of the peritoneal cavity. I opened the old incision and went down until we found the piece, which was not very large, but the cavity I created was very great, and the only thing for me to do was to fill up the space with iodoform gauze, irrespective of what might happen. I really expected the patient to die. It was a case of uterine foetation, where I had to operate on the spur of the moment in a tenement house, and I was surprised

that I did not get more sepsis than developed subsequently, although pus did develop and I had to open the whole thing a week afterward, and had to do it at night to save the patient. I believe we put in nearly a pound of gauze, which was not touched for twelve days, and when I did take it out the whole cavity filled up with urine, and the urine ran from the abdominal wound. I have no doubt the wall of the bladder had been disturbed during the operation, but the mucous membrane had been left intact, and when I removed the gauze I ruptured it.

For a moment a cold chill ran over me, but I said to myself, that bladder must be shut off, and I put in a catheter. It is now healed up entirely, and I believe I never had another so pleasing case as that one. In reference to the removal of small tumors, I believe if the breast is to be touched at all, the operation should be at once thorough and complete. I remember several cases, only one of which I will cite now, in which the surgeon was attempting to make a semicircular incision. He turned the tumor out perfectly, was aseptic in his work, and there was union by first intention. I had advised thorough removal, and the case slipped from my hands. I was present at the operation and congratulated the doctor on it, but I said, notwithstanding all that, I have some misgivings about it. A year later there was never a meaner breast than that one, and the operation to remove it was one of the most terrific ones. It was necessary to go clear down into the axilla. Whether the cure is permanent or not I do not know, but I think there is a renewal of the trouble. If the tumor seems to be a simple lipoma, and it is easily enucleated, perhaps we are warranted in giving that operation a trial, and watch the case afterward. But I do not care how easily the tumor is enucleated, if there is considerable hemorrhage before you get down to it, it is wise to remove the whole breast, for hemorrhage, no matter where, should cause you to suspect malignancy.

Dr. Johnstone: This is the kind of tumor, Mr. President, that we all know nothing but the knife will cure; it is a typical oedematous myomata. The specimen speaks for itself. You all know the old operation of total extirpation of the uterus. I have stated that fully 20 per cent. of these cases have diseased appendages, and there is no doubt but these are diseased. The only point, Mr. President, I could add to it is the method of finding the vagina and getting down to it. There have been many things devised, as staves put in, etc., but in this case the way I found it was, with my assistant's finger in the vagina, I cut in, split it open and cut it out. My idea in doing that was to leave a little of the uterine tissue in the circle, and I believe in that way you do not have so much hemorrhage. The anastomosis from the cervicle ring is not so great as if you cut into the vagina proper. You will have, I think, a better area for drainage, also, by leaving a little of the ring. This is the sixth hysterectomy I have done, and they have all gotten well. Baer cuts the cervix off square; all I meant was to cut into the conal of the cervix. I think the vagina is held open a little better by cutting at the expense of the uterus in peeling it out. But the whole secret of it is to get your drainage thorough and correct. I shut off the peritoneal cavity entirely and did not even use the drainage tube. The drainage occurred through the vagina.

(To be Continued.)

The Obstetrical Society, of Cincinnati, at its annual meeting, elected the following officers for the ensuing year: President, D. A. W. Johnstone; vice president, Dr. Sigmar Stark; secretary, Dr. E. S. McKee; corresponding secretary, Dr. W. D. Porter; treasurer, Dr. George E. Jones.

We are in receipt of a handsome calendar for 1895 from Frederick Stearns & Co.

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THE TUBERCULIN TEST IN CATTLE.

On several occasions we have called attention to the injustice of health boards in compelling herdsmen to submit their cattle to the tuberculin test for consumption. We have repeatedly stated that such a course would not fail to do harm, and it is with profound interest that we note a few recent reports in support of our views.

The danger of applying the tuberculin test to healthy animals lies in the fact that such agent conduces to the formation of lymphatic stasis, and thereby creates a condition favorable for the production of tuberculosis.

At a recent meeting of the dairy-men of Philadelphia and vicinity Dr. Samuel G. Dixon, of the Academy of Natural Sciences, said:

"I have no hesitation in stating that our people are unnecessarily alarmed regarding the danger of contracting tuberculosis from cows'

milk, which fact is to be regretted, as milk is one of our most valuable foodstuffs. It is a perfect food, made up of albumen, casein, fat, sugar, water and salts, formed in the laboratory of nature for the support of animal life. In fact, milk is a necessary article of food for the human family. In childhood and sickness milk is often the only food that can be taken to sustain life. Yet the present exaggerated scare regarding the danger of contracting tuberculosis through the use of milk is so general that physicians in Pennsylvania are experiencing much difficulty in persuading their patients to use cows' milk liberally without more or less nervous tension on the part of the sick, which fact is to be greatly deplored. Regarding the general compulsory use of tuberculin as a diagnostic agent for tuberculous cattle, I can answer most emphatically that I believe, in fact I know, it would be a grave mistake. While tuberculin is certainly useful for diagnostic purposes, it is at the same time a powerful poison that is surrounded by possible dangers. In my laboratory experiments I have produced immunity in the lower animals by the use of dead tubercle bacilli, plus the nidus or medium in which they were grown, which represents tuberculin, yet I produced, to say the least, a predisposition to the disease by the use of larger doses of the same material. Again, I have fully satisfied myself that a latent or a very slow chronic localized condition of consumption can be excited by the use of tuberculin into an active, acute tuberculosis, and occasionally without causing any rise of temperature at the time of test. By its general and indiscriminate use in cattle as a diagnostic agent, a comparatively harmless tuberculosis would often be fanned into a condition that would render innocuous milk poisonous to the consumer. It is, therefore, my opinion that it should, with our present knowledge of its power for good or bad, only be used to diagnose in cases where the doctor is suspicious, but yet in doubt of the presence of tuberculosis."

A letter from Ed. de Freuden-

reisch, of Berne, Minister of Agriculture of Switzerland, written to Dr. I. Cheston Morris, in answer to his inquiry concerning the use of tuberculin, is as follows:

"In answer to your letter of November 20, I can give you the following information: Till now neither the Federal nor the Cantonal Governments have edicted legal prescriptions as to the use of tuberculin to detect the presence of tuberculosis among cattle.

"As to the value of this agent (tuberculin) to detect tuberculosis, I asked the opinion of Professor Guillehean, Professor of the Veterinary School of Berne, where experiments have been made, as also in other parts of Switzerland, and I must say his opinion is not favorable at all to the use of this medicament. It permits, it is true, to detect latent tuberculosis, but it has the inconvenience of generalizing it rapidly in two or three weeks, in cases in which the tuberculosis would perhaps have remained latent for years. It causes, therefore, great loss in cattle and brings, too, danger to those who drink the milk when the latent tuberculosis becomes generalized. Therefore I don't think that the use of tuberculin will ever be rendered obligatory.

"As to the danger raised by tuberculous cattle to public health, M. Guillehean does not think it great, as the general custom is to have the meat well cooked and to drink the milk, at least in the towns, after it has been boiled.

"It is very difficult to say how many per cent. of the cattle are affected by tuberculosis. M. Guillehean thinks it is not frequent in the country. In every case he is of opinion, and I think he is right, that the cattle is always contaminated by the servants. It is now his habit, when making an inquiry in a stable, to look at first the attendants. When these are affected with tuberculosis the cattle are always tuberculous. When the attendants are healthy the cattle do not show any symptoms of tuberculosis. I think it would be for this reason quite useless to introduce the

use of tuberculin, even if the cattle with the symptoms of tuberculosis could be destroyed, as new transmissions of tuberculosis from the attendants to healthy cattle would continue to take place.

"As to the compensations afforded in cases where cattle are to be destroyed in case of infectious diseases, we are about to introduce the system of mutual insurance.

"To conclude, I may say, first, the use of tuberculin is nowhere prescribed legally; second, where it has been used it has caused great losses by generalizing the latent tuberculosis; third, the tuberculosis of cattle seems to proceed always from the human—that is, by transmission from attendants affected with tuberculosis."

Obituary.

A. L. LOOMIS, M. D., LL. D.

The death of Professor Loomis, announced in our issue of January 26, removed from the profession one of the brightest lights of modern times.

A singular fact is often observed in death among medical men, that the cause may be directly or indirectly attributed to diseases of which they have made a specialty. This was true in the case of Dr. Loomis. Pneumonia, from which he died, was a specialty in which he was considered a most efficient consultant.

The rise of Dr. Loomis to professional fame was not sudden. Whatever he attained was by hard work and perseverance. In this he was a worthy example to encourage the plodding practitioner. His opportunities were grasped in the routine order in which they came to him, and faithfulness was manifest in all the undertakings with which he was connected.

Dr. Loomis was born in Bennington, Vermont, on October 16, 1831. After having been graduated from Union College, in 1850, he came to New York and studied medicine with the late Dr. Willard Parker. In

1852 he received his medical degree from the College of Physicians and Surgeons. After serving the regular term of two years on the house staff of the Ward's Island and Blackwell's Island hospitals, he entered upon private practice in New York and devoted himself more particularly to the study of the physical diagnosis of diseases of the chest, a branch of medicine in which he soon won distinction and eventually unexcelled eminence.

He was subsequently appointed a physician to Bellevue Hospital, and held the appointment up to the time of his death. In 1862 he was appointed lecturer on physical diagnosis in the College of Physicians and Surgeons. In 1866 he was made adjunct professor of medicine in the Medical Department of the University of the City of New York, and subsequently he was appointed professor. He held the chair of medicine for the rest of his life, and it was in his didactic instruction in the college and his clinical teaching in the wards of Bellevue that he made himself felt in the profession. He was a member of many medical societies, and a consulting physician to various hospitals. He was president of the New York Academy of Medicine for two terms at a point in its history when much energy, intensity of purpose and sagacity were called for to guide it in safety through the perils of financial undertakings.

The writings of Dr. Loomis are widespread and well known for their practical application and exhibition of sound judgment. He was one of the few that made the subject of medicine an eminent success.

F. RIDGELEY GRAHAM, M. D.

Dr. F. R. Graham, of Chester, Pa., died at his home on Sunday, the 27th of January, from apoplexy. He was born in Chillicothe, Ohio, 69 years ago, and comes of good stock, being a descendant of the Ridgeleys and Greenburys, noted names in the Colonial history of Maryland. The Greenbury mansion at Annapolis was once occupied by F. Stanhope

Hill, the founder of the Chester Evening News.

Dr. Graham was the son of a Presbyterian clergyman, and is a self-made man. In his younger days diligent study and hard work gained an education and graduated from Amherst College, Massachusetts, taking his degree of medicine from the Jefferson Medical College, Philadelphia, where he was a fellow-student he battled through poverty, and by debt with Dr. William B. Ulrich, of this city, in 1850. For a time he lived with his uncle in Cincinnati, Ohio, but later went to Woodbury, New Jersey, and in 1859 he came to Chester, where he has since remained.

Correspondence.

Brooklyn, Feb. 1., 1895.

To the Editor of the Times and Register:

Sir:—I am desirous of adding to the clinical literature of morphinism in children. If any reader of your journal has noted a case and will furnish me details I'll appreciate the favor, and give full credit.

J. B. Mattison.

The following letter has been received, which speaks for itself:

Davenport, Iowa, Jan. 31, 1895.

As a long-time reader of the Times and Register I cannot forego the pleasure of returning my thanks for the admirable paper on consumption that Dr. Parsons has offered its readers, and of saying that I have not read anything so thoroughly valuable in a long time. If the journal contains nothing worth reading for the balance of the year, a supposition most preposterous to those who know the Times and Register, the patrons would have received many times the worth of their money in the excellent paper alluded to. There is no subject about which there clings the mist of uncertainty that has accumu-

lated over the subject of consumption. Dr. Parsons' article must be a revelation to those who have accepted the theories of the books. Such articles as his are what readers of journals yearn for, but seldom get.

Fraternally,
J. A. DeArmand.

Surgery.

DR. T. H. MANLEY, New York.
COLLABORATOR.

INTERESTING STATISTICS IN REGARD TO THE TREAT- MENT OF CANCER.

BY E. H. JONES, M. D.,
PATERSON, N. J.

I notice in the New York Medical Record of August 25, 1894, an article giving some statistics in regard to the treatment of cancer by Dr. W. T. Bull, of New York City. These statistics apply only to cancer of the breast, and the treatment is the ordinary surgical treatment of cancer. This is a record of 75 cases treated previous to 1891. Dr. Bull has taken the usual three years' limit—that is, he is satisfied if the patient has no recurrence of the disease within three years from the date of operation.

The figures as given by him are as follows:

Total number of cases treated prior to 1891	75
Died from the operation	3
Died from recurrence or metastasis	50
Still living after recurrence	2
Died of other diseases after having passed the three years' limit without further manifestation of the cancer	4
Died of other disease during three years following operation	0
Still living without recurrence of the cancer January 1, 1894...	16

According to the above statistics two-thirds of the patients that he treated died from recurrence or metastasis of the disease, and only a little over one-fourth may be considered permanently cured.

These statistics will be about the average of the ordinary surgical treatment of cancer.

In comparison with the above statistics allow me to call your attention to some statistics, giving the results of my treatment of cancer. I have selected 100 cases good and bad, external and internal, that were treated consecutively previous to January 1, 1891.

Total number of cases	100
Died under treatment	1
Died from recurrence of cancer ..	2
Still living, with recurrence	2
Died of other diseases after having passed the three years' limit without further manifestation of the cancer ...	15
Died of other diseases during three years following treatment	14
Still living without any recurrence of cancer, January 1, 1895	66

You will notice from the statistics I have given above that Dr. Bull's cases as reported only refer to cancer of the breast, while the cases as reported by me include all forms of cancer, both external and internal. Dr. Bull reports in his statistics 16 out of 75 permanently cured. In my report you have 66 out of 100 permanently cured. From my own experience in the treatment of cancer, which has covered a period of twenty-five years, if there is a recurrence of the cancer after treatment, it is generally within a year after the treatment of the cancer.

You will notice in my report that two cases out of the 100 died from a recurrence of the cancer, and two are still living with a recurrence of the cancer.

In Dr. Bull's statistics 50 out of the 75 cases he reported died from recurrence or metastasis of the cancer.

I believe that the above statistics will prove interesting reading for intelligent physicians throughout the country, and I am willing to leave it to the average practitioner to decide which plan of treatment they would prefer to use in the treatment of cancer.

DISCUSSION ON APPENDICITIS.

M. Le Gendre opened the discussion by stating that it was a great error to suppose that all intraperitoneal inflammations in the right iliac fossa were of appendicular origin; therefore, the necessity of precision in diagnosis.

He deprecated purgatives in the incipient stages of acute inflammation in the cecal region.

Treatment should consist of absolute repose, with moderate use of opium. He preferred frigorifics to revulsives. Diet should be severely restricted, and if there be much thirst, small pieces of ice may be given. He believes in the free use of large injections of water per rectum.

The patient should be seen two or three times a day. He believed it dangerous to explore under chloroform as recommended by Milliard.

If after 48 hours' active but cautiously directed treatment there is no amelioration, then, an incision should be made into the seat of disease.

Sevestre, who followed, gave a resume of his views on the question of appendicitis. Under the name of perityphilitis, he said, there were conditions widely diverse.

The first and most common, he believed, was purely cecal, relatively benign and curable by medication alone.

The second were of appendicular origin, and of those, too, the majority would do well with constitutional measures alone; but they require a vigorous surveillance, for if serious symptoms suddenly develop we must be ready to operate.

Mathieu stated, that he had carefully examined this question of treatment from various sources, with the result that he was positive that medical treatment would cure the large majority. It was by no means settled whether it was best to interfere rather too much, than too little.

Sonnenburg had operated 77 times with 12 deaths, and was satisfied that the effects on the patient after recovery were not the best.

Richardson in 168 had 42 deaths.

In two he was on the point of operating when consent was refused, and both recovered. But he was not absolutely opposed to operations, and would recommend them in certain desperate cases.

M. du Calgal, of Val-de-Grace, had seen and treated a considerable number of these cases of appendicitis by systemic remedies alone, all recovering. He had found the free use of leeches on the iliac-fossa of great value; besides, the ointments of belladonna or mercury.—Societe des Hospitaux, 3d Nov., '94; Le Merced-Med., 5th Dec., '94.

OCCLUSION OF THE INTESTINE BY THE GRAVID UTERUS.

M. Lotheisen presented at his operative clinic a patient with the phenomena of occlusion of the intestine, by a tumor posterior to the rectum. As a colotomy which had been performed had given little amelioration, he practiced a laparotomy, which exposed the gravid uterus with a pedunculated tumor, which had an opening from the left ovary. The tumor with the ovary was removed and the uterus replaced. Her pregnancy was not interrupted, and she was delivered safely at term.—Gazette Heb., Dec. 17, '94.

Philosophy.

DR. HENRY BURCHARD, Philadelphia.
COLLABORATOR.

Much warfare is waged about the precise definition of the word temptation, many contending, and this justly, that its significance is governed by the individual, and in no two is it alike. After reading much of the testimony the following is offered as a definition:

Temptation is the extent to which the psychical effects of one set of conditions overcome those of another represented by the combined feeling of fear and conscience.

H. B.

Probably no rational individual would oppose the practice of vivisection, were this practice always prompted by an unselfish desire to benefit mankind. Analyzing many of the reports of investigations into this field, one is driven to the deduction that a desire for personal glory is not infrequently the animating force. In many instances the motive impelling the inquirer being, is it possible to have my name identified with a discovery and not, will these investigations be of service in medical art?

A prominent example of this desire is found in the well-known story of Parrhasios. This episode has formed the basis of a dramatization, in which the actor Mantell represents with all its repulsiveness the spectacle of the total subjection of the altruistic to the egoistic; perhaps intentionally this is so clearly presented that any one possessing even a spark of humanitarian spirit is filled with loathing for such motives.

H. B.

Compared with the total number of volumes extant, medical men appeared to have played but small part in general literature; but, as worth, beauty, depth, utility, are not matters of quantity, but of quality, the contributions, few though they may be in point of numbers, are far from insignificant, viewed as to their material and excellence.

Three Philadelphians of the day are prominent in the list: Drs. Garretson, Mitchell and Gould. The readers of this journal are familiar with many of the philosophical writings and teachings of Professor Garretson. Dr. S. Weir Mitchell's reputation as a great physician is permitted to somewhat obscure his position as a poet and novelist; and yet no writer of his time has a keener insight as to affairs, character, and the cause and being of human action than has he.

The observations, which can alone be made by the cultured physician, are turned to the purposes of character exposition, and these characters,

while losing neither beauty nor distinctiveness, are true generalizations of types of the genus homo. Dr. Mitchell applies, and most skillfully, psychology to the novel, and through it adds rather than detracts from romance and poetry. Apropos of this, his novel, "Characteristics," forms in part a fascinating contribution to the study of medical psychology, and without the features of a "medicated" novel. Weighed impartially, his novels will be found among the best, if not the best, for character analysis, philosophy, aesthetics, and high in the list of pure romances.

The various reviews have given extended and favorable notices of Dr. George M. Gould's book, "The Meaning and Method of Life." No doubt everyone has sought to give expression to the feeling of nothingness which pervades every man who star-gazes; the feeling of the comparatively infinitesimal, when viewing and mentally measuring sizes and distances of and between stars and nebulae; the helplessness and hopelessness possessing one when he weighs himself as a cosmic particle; Dr. Gould sums up these tangled emotions in the phrase, "Cosmic horror," and who among thinkers does not owe him a debt for the words? Taken as a whole, his work is one of the few thoroughly original contributions to philosophy. The finding and placing of an incarnate, yet intangible God, the naming of it or Him, Biologos, and there may be made upon this as sound a theological system as is possible.

The field of every science has been scoured to provide material for argument in the work; so that beside what is usually made speculative thought is placed demonstration, founded upon researches into molecular physics, the chemistry of the carbon, compounds and cell biology, and so on. Dr. Gould's skill in the selection of words, phrases and arguments is well known and applied to the thought vivifying this book, there results a volume of such excellence that no investigator can afford to leave it unread.

H. B.

Wayside Notes.

A brilliant homeopathic physician furnishes a paper in which he maintains that all the cases of cancer he had observed in thirty years' practice were produced by anxiety. As we all have had a little of that up to the present time, it is proper to ask why we too have not succumbed. According to the learned doctor this fact affords an additional proof of his contention. It shows a general immunity from cancer similar to that which protects the majority of persons from other diseases. See? I am sure I don't.

Is there aught in dreams? A patient of mine, who could fill a book full of strange visions and dreams, had one the other night that proved at least a valuable coincidence. Her husband holds an important position as a skilled workman in laying electric cables. For some time he has had an enemy in the shape of a fellow-workman, who is envious of his position, and would stoop to any action in order to dispossess the other man.

On the night in question my patient dreamed that she saw the envious workman with his helper go to the manhole in the absence of her husband, and do something, she could not see exactly what, with the open tube on which her husband had previously been working. The next morning she warned her husband to be on the watch against this man. That same day after the dinner hour, her husband, before proceeding to work, examined the tube carefully and found that a lot of water had been poured in it during his absence. Inquiry brought out the fact that the other workman with his helper had been seen coming out of this hole—a place where they had no business to be. But for his wife's warning dream, he would not have thought of examining the tube; the water left in there would have done anywhere from one to five hundred dollars' worth of damage; besides the job would have been condemned at the

final test, and the husband of my patient, who was responsible, would probably have lost his position on the charge of carelessness.

An acquaintance of mine heard some time ago in an English church an announcement given out in a manner so ambiguous as to cause a slight smile to wander over the congregation. Said the parson: "There will be a baptism of adults at the northeast corner, a baptism of children at the southwest corner, and a baptism of infants at both ends."

A colored dispensary patient was recently asked whether he ever went on sprees, and to this question he promptly replied: "No, sah; I never drinks to success."

The other day a friend of mine received the following interesting specimen of that vernacular in which the Queen is supposed to delight: "Doctor, my wife complains of Soringness a Round her Stomach and i woul lack For you to come down and Sea hear if you can to-day."

Miscellany.

THE NATURE OF IMMUNITY.

In a lecture delivered before the International Congress of Hygiene, Professor Buchner, of Munich, summarized his conclusions in regard to immunity and immunization. Natural and acquired immunity he considered differed in principle. The natural power of resistance is due to the bactericidal influence of the alexines, certain dissolved constituents of the organism and to a congenital power of resistance in the tissues and cells of the body. The leucocytes play an important part in this natural protection, not through phagocytosis, but by means of dissolved substances they secrete. The immunity artificially acquired or the immunity acquired in later life is due to the presence of modified bacterial products—the antitoxines. The action of the antitoxines is not directly upon bacterial products, but

by modifying the organism these enable it to resist specific poisons. This is essentially the doctrine most prevalent.—Physician and Surgeon.

VALUE OF HUMAN LIFE.

It may be interesting to know what a human life is worth. This has been a mooted question, but appears to have been decided in New York State, where \$5000 is the extreme amount that can be collected as damages in case an individual is killed through the neglect or carelessness of another person or of a corporation (Ex.).

The law was passed through the powerful influence of the railroad companies centering in New York, and all efforts to have it repealed have thus far proved unavailing. Possibly \$5000 is all a New Yorker's life is worth, but other States set a higher value on their citizens. Further, several of the State constitutions distinctly declare that no law shall be enacted establishing the amount of damages that may be collected for causing death or injury to a person.—St. Louis Medical-Journal.

CAUTERIZING OVARIES INSTEAD OF REMOVAL OF THEM.

Dr. Pozzi, at Hôpital Broca, has now practiced cauterization of painful ovaries for over two years, and considers the plan very successful. In one case in which he operated upon both ovaries the woman has since given birth to a child. He performs his laparotomies in the ordinary recumbent position; draws the ovaries out of the abdominal opening. If the ovary is totally diseased he removes it; but if a part is found to be healthy he amputates the affected portion, cauterizes the stump, and sews the end with silk. If there are some small cysts he opens them by touching them with the Poquelin point. The ovary being returned to the abdomen he examines and treats the other in a similar manner. Often as many as six small cysts are opened in this way in each ovary.—Therapeutic Gazette.

SULPHO-CARBOLATE OF SODIUM IN PURPURA HEMORRHAGICA.

Dr. Sansom reports a case occurring in a girl, aged 12, where the extravasations occurred not only over the skin surface, but also upon the nasal, gastric, intestinal, vesical and bronchial mucous membranes. He believes it to be due to influenza, and good results were obtained from the administration of sodium sulphocarbolate in half-drachm doses every four hours.—Lancet, June 2, 1894.

THE COMPENSATORY ACTION OF THE CEREBRAL HEMISPHERES.

Marie de Manaccin (Neurol. Centralbl., November 15, 1894) has tested this capacity by various methods. Assuming that sleep is most profound during the first two or three hours, and that the left cerebral hemisphere normally being the seat of the speech and the right hand centres is more active in working state, and therefore more exhausted and less accessible to stimuli than the right during sleep, it was found that on lightly tickling either side of the face of ordinary persons in this stage of somnolence the sleeper made repellent movements invariably with the left hand, even when from lying on the left side it was necessary for the sleeper to withdraw the limb from beneath the body. In eight left-handed persons the right limb alone was moved. These experiments, the author maintains, are demonstrative of the compensatory or vicarious action of the one cerebral hemisphere during deep sleep. As further illustrations of the point, it is mentioned that in dogs exhausted by complete deprivation of sleep reflex movements only occurred on one or other side, alternating periodically as if one half of the brain were temporarily asleep. In cases of left hemiparesis, with disturbances of speech and writing, the latter act could be accomplished with the left hand better during the attack than at other times.